

MAR 13 1937

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

6600

1. PLACE OF DEATH

County *Jackson*Registration District No. *399*File No. *525*Township *1st*Precinct Registration District No. *1002*Registered No. *325*City *St. Louis* (No. *1*)General Hosp. #2 St. *3rd* (Ward)

2. FULL NAME

(a) Residence, No. *2104 E. 14th* St., Ward. *1*

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *Colored* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF *Unknown*6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Unknown*7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *74* — —OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *None* 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*FATHER 13. NAME *Grove Michels*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis*MOTHER 15. MAIDEN NAME *Unknown*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis*17. INFORMANT (ADDRESS) *Record Clerk, General Hospital*

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Westlawn* DATE *2/25*, 19*37*19. UNDERTAKER (ADDRESS) *A. B. Moore, 1820 E. 18th St.*20. FILED *724*, 19*37* *M. M. Groves* Registrar21. DATE OF DEATH (MONTH, DAY, AND YEAR) *2-19*, 19*37*22. I HEREBY CERTIFY, That I attended deceased from *2-15*, 19*37*, to *2-19*, 19*37*I last saw him alive on *2-19*, 19*37*. Death is said to have occurred on the date stated above, at *5:00 A. M.*

The principal cause of death and related causes of importance were as follows:

Date of onset

Broncho - Pneumonia

Other contributory causes of importance:

Name of operation *107a* Date of *Yes*

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? *No*

If so, specify

(Signed) *J. C. Thompson, M. D.*(Address) *General Hosp. #2*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

